Nos. 96-110, 96-1858

IN THE
# Supreme Court of the United States
OCTOBER TERM, 1996

STATE OF WASHINGTON, *et al.*,
*Petitioners,*
v.
HAROLD GLUCKSBERG, M.D., *et al.*,
*Respondents.*

DENNIS C. VACCO, *et al.*,
*Petitioners,*
v.
TIMOTHY E. QUILL, M.D., *et al.*,
*Respondents.*

**On Writs of Certiorari to the United States Courts of Appeals for the Ninth and Second Circuits**

## BRIEF *AMICUS CURIAE* OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

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### INTEREST OF THE *AMICUS CURIAE*

*Amicus curiae*, the American Hospital Association ("AHA"), respectfully submits this brief in support of Petitioners in *State of Washington v. Glucksberg*, No. 96-110, and *Vacco v. Quill*, No. 96-1858.[1]

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[1] The AHA has the written consent of Petitioners and Respondents in both cases to the filing of this brief. Letters indicating their consent have been filed with the Clerk of the Court.

Founded in 1898, the AHA is the primary organization of hospitals in the United States. The AHA's mission is to advance the health of individuals and communities. AHA leads, represents, and serves health care provider organizations that are accountable to the community and committed to health improvement. Its membership includes 70% of the Nation's 5,000 hospitals, health systems, and other providers of care. Over 38,000 health care professionals hold individual memberships in the AHA.

The AHA has played a significant role in the ongoing debate concerning end-of-life decisions. It has worked vigorously through the legislative and judicial processes to help secure the right of patients, in consultation with their families and their physicians, to forego life-sustaining medical treatment.[2] And it regularly publishes policies and ethical guidelines addressing the roles of patients, families, guardians, physicians, and hospitals involved in termination-of-care decisions.

The AHA and its members have a vital interest in the outcome of *Glucksberg* and *Quill*. If a constitutional right to physician-assisted suicide is recognized, AHA members will be called upon to assist in the suicide of patients on a daily basis in hospitals across the country. In the view of the AHA, recognition of such a right would create an administrative nightmare for hospitals and other health-care providers as courts struggle to define the parameters of this new right. For this and other reasons described below, the AHA joins virtually every medical association and governmental panel to study the issue in opposing the creation of a constitutional right to physician-assisted suicide.

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[2] *See, e.g.*, Brief of the AHA as *Amicus Curiae*, in Support of Petitioners in *Cruzan v. Director of Missouri Dep't of Health*, No. 88-1503 (S. Ct. Sept. 1, 1989) (urging recognition of right to refuse medical treatment).



## SUMMARY OF ARGUMENT

The American Hospital Association supports the right of every patient to choose whether or not to accept medical treatment. This right includes the right to forego even life-sustaining medical treatment, including artificially delivered food and water. Patients, in consultation with their families and their physicians, should be able to make such determinations free from government interference. The right of a patient to accept or reject medical treatment is in keeping with a doctor's well-recognized obligation not to force treatment on an unwilling patient. It is also consistent with this Court's precedents and with the deeply-rooted traditions of this country.

A right to physician-assisted suicide, by contrast, finds no basis in the text or structure of the Constitution or in this Court's precedents. Nor is such a right so "deeply rooted in this Nation's history and tradition," *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977), that it may be deemed "fundamental" or "implicit in the concept of ordered liberty," *Palko v. Connecticut*, 302 U.S. 319, 325 (1937). To the contrary, physician-assisted suicide has long been illegal and continues to be so in the vast majority of states.

The American Hospital Association does not endorse state statutes criminalizing physician-assisted suicide. But the AHA cannot accept the assertion that the Constitution precludes such statutes. Under our system of government, democratically-elected officials should be able to grapple with this difficult issue free from "a background of federal constitutional imperatives that are unknown because they are being newly crafted from Term to Term." *Cruzan v. Missouri*, 497 U.S. 261, 293 (1990) (Scalia, J., concurring). Hospitals, medical associations, individual physicians, and their patients and communities should all be able to take part in shaping public policy on this issue based on ethical, medical, and political considerations. The Constitution does not preempt such informed dialogue.

Accordingly, the AHA believes that the Ninth Circuit decision being reviewed by this Court is both wrong and profoundly damaging to our constitutional scheme. The AHA also believes that the Second Circuit erred in failing to recognize a rational distinction between assisted suicide and the right to refuse medical care, which the AHA has long-championed.

## ARGUMENT

### I. THERE IS NO CONSTITUTIONALLY-PROTECTED LIBERTY INTEREST IN PHYSICIAN-ASSISTED SUICIDE

#### A. A Constitutionally-Protected Liberty Interest in Physician-Assisted Suicide Has No Basis in the Text or Structure of the Constitution or in This Court's Precedents

This Court has been understandably reluctant in recent years to expand the range of substantive due process rights protected by, though not mentioned in, the Constitution.

> The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional laws having little or no cognizable roots in the language or design of the Constitution. That this is so was painfully demonstrated by the face-off between the Executive and the Court in the 1930's, which resulted in the repudiation of much of the substantive gloss that the Court had placed on the Due Process Clauses of the Fifth and Fourteenth Amendments. There should be, therefore, great resistance to expand the substantive reach of those Clauses, particularly if it requires redefining the category of rights deemed to be fundamental. Otherwise, the Judiciary necessarily takes to itself further authority to govern the country without express constitutional authority.

*Bowers v. Hardwick*, 478 U.S. 186, 194-95 (1986).



The Ninth Circuit does not suggest that there is any basis in the language or design of the Constitution for a right to physician-assisted suicide. Rather, the court of appeals attempts to base its decision on two prior decisions of this Court, neither of which will bear that weight. *See Compassion in Dying v. State of Washington*, 79 F.3d 790, 812-16 (9th Cir. 1996) (relying on *Cruzan* and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992)).

In *Cruzan*, 497 U.S. at 278, the Court correctly recognized that its prior decisions supported "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment." At common law, every individual had a right to "bodily integrity," to be free of any physical intrusion without consent. Any unconsented to touching was a battery. Out of this right to be free of battery grew the doctrine of "informed consent" and its "logical corollary," which is that "the patient generally possesses the right not to consent, that is, to refuse treatment." *Id.* at 269-70. The right to refuse treatment was universally recognized in state law cases and in a series of Due Process Clause decisions leading up to *Cruzan*. *Id.* at 269-78.

In *Cruzan*, the Court assumed without deciding that "under the general holding of our cases, the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life, would implicate a competent person's liberty interest." *Id.* at 279. In other words, the Court assumed that the long-recognized right to refuse medical treatment includes the right to refuse even treatment necessary to sustain life. The Ninth Circuit has taken that assumption, which was well-grounded in the Court's precedents, and run with it into a wholly "uncharted area" where the "guideposts for responsible decisionmaking . . . are scarce and open-ended." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992).

The Ninth Circuit claims that "*Cruzan*, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognizes a liberty interest in hastening one's own death." 79 F.3d at 816. From there, the court of appeals finds that if an individual has a right to commit suicide, he must have a right to assistance in committing suicide. Otherwise, "the state's prohibition on assistance [would] unconstitutionally restrict[] the exercise of that liberty interest." 79 F.3d at 801 (citing *Roe v. Wade*, 410 U.S. 113 (1973)). And from a right to physician-assisted suicide, the Ninth Circuit—acknowledging that the question is not even before it, but apparently unable to contain its momentum—proceeds to a right to physician-administered suicide (*i.e.*, voluntary euthanasia). *Id.* at 831.

By this series of little or not so little steps, a complete perversion of the Court's holding in *Cruzan* is effected. The ultimate basis for the right to decline medical treatment recognized in *Cruzan* lies in the common law of battery. Unwanted medical care is an unconsented to touching, and it is in that sense that it implicates the liberty interest protected by the Due Process Clause. But physician-assisted suicide has nothing to do with an unconsented to touching. It involves making it possible for the patient himself to take a voluntary action. Neither touching (*i.e.*, the actual administration of medicine) nor a lack of consent is involved. The protection of bodily integrity from unwanted physical invasions is simply not implicated by physician-assisted suicide.

As discussed in more detail below, there is a legitimate and important policy distinction between a patient's decision to decline all treatment and a doctor's decision to prescribe drugs for the express purpose of inducing the patient's death. For present purposes, however, it is enough to recognize that a right to physician-assisted suicide finds no conceivable support in the common law of battery and in the informed consent and related cases



upon which the *Cruzan* Court relied. Torn from its moorings in history, the right championed by the Ninth Circuit is a free-floating derelict that can only wreak havoc on our constitutional structure.

A right to physician-assisted suicide finds even less support in *Planned Parenthood v. Casey*. The Ninth Circuit leans heavily on a single paragraph plucked out of the *Casey* plurality's 30-page opinion, a paragraph moreover that discusses only in the most general terms the constitutional significance of "intimate and personal choices" that are "central to personal dignity and autonomy." *Casey*, 505 U.S. at 851. From this the Ninth Circuit remarkably concludes that the Supreme Court has provided an "almost prescriptive" mandate requiring recognition of a fundamental liberty interest in assisted suicide. 79 F.3d at 813 (citations omitted).

But *Casey* was never intended to be read so broadly. In the first place, the plurality's opinion rests at heart upon *stare decisis* principles, upholding the abortion right largely because of the need to protect and respect prior court decisions in the abortion field extending back to *Roe v. Wade*. *See Casey*, 505 U.S. at 854-69. Indeed, the plurality's reliance on *stare decisis* in Section III of its opinion was entirely sufficient to decide the controversy before the Court in *Casey*. Consequently, the very general autonomy discussion found earlier in Section II upon which the Ninth Circuit so heavily relied is no more than dicta of a mere plurality of the Court.

Even if *Casey* is read as a re-approving (and not just declining to overrule) a due process right to abortion, the two contexts are entirely different. As Judge Noonan noted below, "[i]t is commonly accounted an error to lift sentences or even paragraphs out of one context and insert the abstracted thought into a wholly different context." *Compassion in Dying v. State of Washington*, 49 F.3d 586, 590 (9th Cir. 1995). This Court has concluded that abortion does not involve the taking of a human life,

because a fetus is not a "person" under the Fourteenth Amendment. *Roe*, 410 U.S. at 157-58. But no one could claim that physician-assisted suicide is not the deliberate taking of a human life, and that fact gives rise to legitimate state interests in preventing physician-assisted suicide that are not implicated in the abortion context.

The Ninth Circuit's reading of *Casey*'s autonomy discussion goes too far in other respects as well. If the Constitution protects as a fundamental liberty interest every "intimate" or "personal" decision, as the Ninth Circuit suggests, this Court must acknowledge frankly that *Bowers v. Hardwick*, 478 U.S. at 191, is no longer the law (something the Ninth Circuit strongly hints should happen). And it must be prepared for future automony-based constitutional challenges to laws banning any private consensual act of significance to the participants in defining their "own concept of existence." *Casey*, 505 U.S. at 851. As Judge O'Scannlain queried: "If physician-assisted suicide is a protected 'intimate and personal choice,' why aren't polygamy, consensual duels, prostitution, and, indeed, the use of illicit drugs?" *Compassion in Dying v. State of Washington*, 85 F.3d 1440, 1444 (9th Cir. 1996) (dissenting from denial of rehearing en banc by the full court).

Finally, even if the Court could somehow restrict the right of "intimate and personal choice" to physician-assisted suicide, it would still be enmeshed in endless problems of line drawing of the sort that have plagued the Court's abortion jurisprudence. As the Ninth Circuit itself conceded, the federal courts will have to determine what "appropriate, reasonable, and properly drawn safeguards" states are permitted to devise to control physician-assisted suicides. 79 F.3d at 833. Once again, states will be legislating "against a background of federal constitutional imperatives that are unknown because they are being newly crafted from Term to Term." *Cruzan*, 497 U.S. at 293 (Scalia, J., concurring).



This process of uncertainty will place a severe burden on hospitals and other health care providers that will be called upon to provide physician-assisted suicide. They will be acting against a background of uncertainty and potential liability for years to come. Moreover, they will be under great pressure to provide a service that some providers consider antithetical to the integrity of their profession and their own sense of ethics. The patient's right to abortion has been distorted by at least one court into an obligation placed on a private hospital—deemed "quasi-public" in part because of its acceptance of some public funding, but primarily because "[t]he hospital was the only one serving the community"—to make its facilities available for non-therapeutic (elective) abortions. *Mat-Su Coalition for Choice v. Valley Hosp. Assoc.*, No. 3PA-92-1207, slip op. 11 (Alaska Super. Ct. Feb. 9, 1993). If the courts feel free to override the conscience of health care providers in that context, there is a danger they will do so here as well.

Justice O'Connor stated in *Casey* that abortion is "unique" in American constitutional jurisprudence. *See* 505 U.S. at 852 (concurring). Given the problems of legitimacy and line-drawing inherent in the Court's abortion rulings, it would be a "great misfortune" if the Court were to embark on a comparable venture here. *Cruzan*, 497 U.S. at 293 (Scalia, J., concurring).

### B. A Constitutionally-Protected Liberty Interest in Physician-Assisted Suicide Is Not So Rooted in Our Traditions That It May Be Deemed "Fundamental"

Before it recognizes any new liberty interest, the Court has required that the asserted interest be "so rooted in the traditions and conscience of our people as to be ranked as fundamental."[8] Far from being rooted in our tradi-

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[8] *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934); *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977) (requiring proof

tions, physician-assisted suicide has long been illegal and continues to be so in the vast majority of states.

Forty-five states and the District of Columbia currently forbid assisted suicide.[4] At the time of the adoption of the Fourteenth Amendment in 1868, "twenty-one of the thirty-seven states, and eighteen of the thirty ratifying states prohibited assisted suicide." Thomas J. Marzen, Mary K. O'Dowd, Daniel Crone & Thomas J. Balch, *Suicide: A Constitutional Right?*, 24 Duquesne L. Rev. 1, 76 (1985). Moreover, "most States that did not explicitly prohibit assisted suicide in 1868 recognized, when the issue arose in the 50 years following the Fourteenth Amendment's ratification, that assisted and (in some cases) attempted suicide were unlawful." *Cruzan*, 497 U.S. at 295 (Scalia, J., concurring) (citing Marzen *et al.*, 24 Duquesne L. Rev. at 77-100).

At common law, assisted suicide was also forbidden. As a prominent 19th century treatise explained, the consent of the victim is "wholly immaterial to the guilt of the person who causes [his death]."[5] Court after Court reached the same result.[6]

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that the asserted interest is "deeply rooted in this Nation's history and tradition"); *Michael H. v. Gerald D.*, 491 U.S. 110, 123 (1989) (plurality opinion) (insist[ing] that the asserted liberty interest be rooted in history and tradition").

[4] *See* Edward R. Grant and Paul B. Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure 16*, 74 Ore. L. Rev. 449, 462 (1995) (citing state statutes).

[5] Sir James Fitzjames Stephen, 2 *A History of the Criminal Law of England* 16 (1883).

[6] *See, e.g., Wharton's Criminal Law* § 46, at 232-33 (Charles E. Torcia, ed. 1978); Wayne R. LaFave & Austin W. Scott, Jr., *Criminal Law* 477 (2d ed. 1986); *Gospodareck v. State*, 666 So. 2d 835, 842 (Ala. Crim. App. 1993); *State v. Fuller*, 278 N.W. 2d 756, 761 (Neb. 1979); *State v. Mays*, 307 S.E.2d 655 (W. Va. 1983); *State v. Cobb*, 625 P.2d 1133 (Kan. 1981); *Turner v. State*, 108 S.W. 1139 (Tenn. 1907); *People v. Matlock*, 336 P.2d 505 (Cal. 1959 (*en banc*)); *State v. Bouse*, 264 P.2d 800 (Ore. 1953); *People v. Roberts*, 178 N.W. 690 (Mich. 1920).



Moreover, neither the common law nor any statutory proscription of assisted suicide has ever made any distinction based on the physical condition of the suicide or the time left to him. That the suicide was about to die anyway, or would have had a more painful natural death than the one provided him by the assistant, has been treated as no defense to assisted suicide. Thus, in *Blackburn v. State*, 23 Ohio St. 146 (1872), the Ohio State Supreme Court explicitly remarked that

> [t]he lives of all are equally under the protection of the law, and under that protection to their last moment. The life of those to whom life has become a burden—of those who are hopelessly diseased or fatally wounded—nay, even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment, and anxious to continue to live.

*Id.* at 163. *See also People v. Roberts*, 178 N.W. at 693 (same); *Commonwealth v. Bowen*, 13 Mass. 356, 360 (1816) (prisoner who persuaded another to comimt suicide can be tried for murder, even though the suicide was scheduled for imminent execution; it is irrelevant "that but a small portion of [the suicide's] earthly existence could in any event remain to him.").

In short, the supposed right to assisted suicide recognized by the court below is unprecedented in the law of this Nation and in our common law origins. Under the circumstances, such a right can hardly be said to be so rooted in our traditions as to warrant constitutional recognition.

### C. States Have Compelling Reasons to Ban Physician-Assisted Suicide

Even if the Court were to find some sort of liberty interest in assisted suicide, states can still ban the practice if they have compelling reasons to do so. *Cruzan*, 497 U.S. at 280 (" 'whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests' ") (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)).

Petitioners and their other *amici* describe in detail the various state interests underlying a ban on physician-assisted suicide. The AHA will not repeat that discussion here. Nor does the AHA endorse any conclusion that the balance of considerations, as a policy matter, favors criminalizing physician-assisted suicide. But, as a matter of constitutional law, it should be clear that the various state interests are sufficient to allow a state, if it so chooses, to override any alleged liberty interest of the patient in obtaining assistance to commit suicide.

Herein lies the most offensive aspect of the Ninth Circuit's decision. The court arrogantly and disdainfully dismisses the state interests supporting a ban on assisted suicide simply on the grounds that it disagrees with them. *See* 79 F.3d at 816-32. But there is no single right answer to such a difficult issue as assisted suicide. There are instead a whole series of counterveiling considerations that tug policy makers first in one direction, then in another. Different states, forced to make a choice, will diverge in their approaches.

The Court's suggestion in *Cruzan* that any liberty interest must be balanced against relevant state interests could not have been intended to suggest that there is only one right answer to such questions, much less that the answer lies in the sole possession of the judiciary. As long as a state can articulate compelling policy justifications for banning the practice, the Court cannot substitute its own policy analysis for that of the state. As Judge Kleinfeld explained below: "The Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions would be decided by the judiciary." 79 F.2d at 858.



## II. THERE IS A RATIONAL BASIS FOR THE DISTINCTION BETWEEN ASSISTED SUICIDE AND THE REFUSAL OF MEDICAL TREATMENT

"It is not the province of this Court to create substantive constitutional rights in the name of guaranteeing equal protection of the laws." *San Antonio Indep. Sch. Dist. v. Rodriquez*, 411 U.S. 1, 33 (1973). Yet that, of course, is precisely what the Second Circuit has done in concluding that the State of New York cannot allow patients to refuse life-sustaining medical treatment while, at the same time, forbidding physician-assisted suicide. The Second Circuit, just like the Ninth, has taken the right of a competent adult to refuse medical care and blown it up into a general right to "hasten death," which it then concludes must rationally embrace the right to physician-assisted suicide.

Under this Court's precedents, New York need only establish that the statutory distinction at issue is "rationally related to a legitimate state interest." *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985). This New York can easily do. Physician-assisted suicide by definition involves an *intention* on the part of both doctor and patient that the patient die. The withdrawal of care, though it may also result in death, need involve no comparable intent on the part of the physician or even the patient. That difference provides ample support for the statutory distinction drawn by New York.

Under New York penal law, and the law of virtually all other jurisdictions, a person is guilty of assisted suicide

only if he "*intentionally* aids another person to commit suicide" (emphasis added).[7] Suicide itself has always been understood as an intentional act.[8] Thus, to be guilty of the crime of assisted suicide, one must intentionally aid another person who intends to kill himself.[9]

New York's assisted suicide law is absolute and creates no classifications on its face. *All* intentional acts of aiding another intentionally to kill himself are proscribed. Nonetheless, the Second Circuit reasons that New York treats similarly-situated classes of persons differently because it

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[7] N.Y. Penal Law § 125.15 (McKinney 1987); *see also id.* at § 120.30 ("A person is guilty of promoting a suicide attempt when he *intentionally* . . . aids another person to attempt suicide.").

[8] *See, e.g.*, Model Penal Code and Commentaries § 210.5, comment 1, at 91-92 (1980) (common law crime of suicide "consisted of intentional self-destruction by a person of sound mind and body"); John Bouvier, Law Dictionary and Concise Encyclopedia 3178 (3d ed. 1914) ("To be guilty of [suicide], the deceased must have had the will and intention of committing it, or else he committed no crime."); Sir Matthew Hale, 1 *Pleas of the Crown* at 411 (1847) (crime of *felo de se* requires proof that suicide "voluntarily kill[ed] himself"); E. Wingate, *Justice Revisited: Being the Whole Office of a County Justice of the Peace* 61, 88 (1661) (the crime of *felo de se* requires proof that a person "destroy[ed] himself out of premeditated hatred against his own life"); Sir William Blackstone, *Commentaries on the Laws of England* 189 (1769) (act must be undertaken "deliberately" or as part of an "unlawful malicious" act).

[9] The intent component of assisted suicide and suicide has always been critical to prevent overinclusiveness problems. If the mental element required were "knowledge" that death would result, many martyrs would be "suicides" and those who aided them guilty of assisted suicide. And the same would hold with soldiers who went ashore at Normandy and those who supported them. Several hundred years ago Hale illustrated the absurdities that would result if intent were not part of the very definition of suicide: "If A., with an intent to prevent gangrene beginning in his hand doth without any advice cut off his hand, by which he dies [bleeding to death], he is not thereby *felo de se*, for tho it was a voluntary act, yet it was not with an intent to kill himself." Hale, 1 *Pleas of the Crown*, at 412.



recognizes a patient's right to withhold or withdraw life-sustaining medical treatment while at the same time it refuses to allow "self-administr[ation] [of] prescribed [lethal] drugs" to "hasten death." *Quill v. Vacco*, 80 F.3d 716, 729 (1996).

This reasoning overlooks a key distinction. In *all* cases where the physician prescribes and the patient administers a lethal dose of drugs to hasten death, the *intent* of both doctor and patient is to see the patient die. Indeed, if the patient continues to live by accident, that represents a frustration of the patient's and physician's will, and to effectuate their plans the parties will have to try again.[10] By contrast, in refusal of care cases, the physician and patient may *know* that removing the respirator or stopping the feeding tube will result in death, but they need not *intend* it. If the patient somehow manages to live without the rejected care, it may actually be a cause for celebration, not regret or frustration.[11]

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[10] *See "If the Drink Does Not Work, The Syringe Is At Hand"*, Nederlands Dagblad (July 6, 1994) (quoting Dutch physician) (translated from the Dutch: "Als het drankje niet werkt, dan ligt de spuit al klaar").

[11] The Second Circuit muddies the waters by suggesting physicians assisting suicide intend only to relieve suffering. *See Quill*, 80 F.3d at 730 ("[a]nd what business is it of the state to require the continuation of agony"). But the physicians-respondents in both the Second and Ninth Circuit cases themselves *concede* they *intend* to see their patients die (if only as a means to their *further* intention of relieving suffering). *See, e.g., id.* at 719 (physicians conceding that they wish to violate New York law banning intentionally aiding in suicide). And, indeed, they must make that admission: if they lacked the intent to help kill they would by definition be innocent of assisting suicide and lack standing to pursue this claim. Physician-respondents readily concede, in sum, that they *intend to kill*, even if they are motivated by a further intent to stop suffering. *See* New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, at 61 (May 1994) ("it is significant that intent does not mean motive, and does not imply an evil state of mind.

Even where death is inevitable, the decision not to prolong life at the cost of invasive care is not the same as the intent to cause death. It has become increasingly common for patients either to refuse "basic" life-sustaining care such as feeding or hydration tubes, or to leave behind "living wills" requiring that such treatment not be given. No intent to die is necessarily involved in such instructions. To the contrary, the intention is usually to avoid the discomfort and perceived indignity such care involves.[12]

If a soldier accepts death in battle to avoid dishonor in running away, he does not commit suicide, and the general who orders him into battle does not murder him. Similarly, if a patient accepts death to avoid the pain and indignity of continued treatment, he does not commit suicide, and the doctor who respects his wishes does not murder him. "To call these judgments [to refuse or withdraw treatment] 'intending' death distorts what actually happens. . . . [I]f I stop shoveling my driveway in a heavy snowstorm because I cannot keep up with it, am I thereby intending a driveway full of snow?" Daniel Callahan, *The*

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The fact that the physician acts benevolently, out of compassion for the patient, would not be a defense to liability [for assisted suicide]").

[12] *See, e.g.*, New York State Task Force at 146 ("[i]n many cases, the patient must also be physically restrained to accept treatment"); Alan Meisel, *The Right to Die* 98 (1992 Supp.) (noting that up to 53% of patients require physical restraints to keep them from removing feeding and hydration tubes); *id.* (noting that feeding and hydration tubes can cause substantial pain and discomfort since tubes inserted directly into the stomach necessitate a surgical procedure which "may lead to leakage of acidic stomach contents, causing sores and infections"); Jacquelyn A. Beatty, Comment, *Artificial Nutrition and the Terminally Ill: How Should Washington Decide?* 61 Wash. L. Rev. 419, 425 (1986) (nasogastric tubes can "painfully irritate the patient, causing bleeding and ulceration. Tubes can be misplaced, which may lead to infection and death. Aspiration-included pneumonia is a frequent complication").



*Troubled Dream of Life: Living with Mortality*, 77-78 (1993).[13]

In the course of recognizing the right to refuse medical care, New York State has explicitly recognized that withdrawing medical care need not involve any intent to kill and, thus, in no way sustains or supports a right to assist suicide. *See Eichner v. Dillon*, 426 N.Y.S.2d 517, 544 (1980) ("the withdrawal of the respirator evinces only an intent to . . . allow the processes of nature to run their course"). Court after court across the country has likewise found that because the patient and physician at issue sought to discontinue medical care without *intending* death, their actions did not constitute suicide or implicate laws banning assisted suicide.[14]

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[13] It is commonplace for Jehovah's Witnesses or Christian Scientists to refuse blood transfusions or life-saving surgery and die as a direct result, yet we hardly call these acts of suicide because no *intent* to die is involved. Death may be accepted as a consequence, but it is not purposely sought.

[14] *See, e.g., McKay v. Bergstedt*, 801 P.2d 617, 625-26 (Nev. 1990) (holding refusal of life-sustaining care not tantamount to suicide since "Kenneth harbored no intent to take his life . . . he did not seek his own destruction. Unlike a person bent on suicide, Kenneth sought no affirmative measures to terminate his life . . . he asked no one to shorten the term of his natural life free of the respirator"); *Application of the President & Directors of Georgetown College*, 331 F.2d 1000, 1009 (D.C. Cir. 1964) (Skelly Wright, J.) (in case where patient refuses blood transfusion, "[t]he Gordian knot of this suicide question may be cut by the simple fact that Mrs. Jones did not want to die."); *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. App. 1978) ("The testimony of Mr. Perlmutter . . . is that he really wants to live, but to do so, God and Mother Nature willing, under his own power. This basic wish to live plus the fact that he did not self-induce his horrible affliction, precludes his further refusal of treatment from being classed as attempted suicide."); *In re Claire C. Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) (declining life-sustaining treatment distinguishable from suicide because it "merely allows the disease to take its natural course"); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Cal. App. 1986) (a "decision to allow nature to take its course is not equivalent

The State surely has a legitimate interest in choosing not to wade across the moral Rubicon that has always separated intentional killings from unintentional ones. *See, e.g.*, New York State Task Force at 112 ("[f]or many, the prohibition against actively and intentionally killing innocent persons represents a basic moral and social norm. Diverse philosophical and religious perspectives affirm this view."); House of Lords, *Report of the Select Committee on Medical Ethics* 53 (1994) ("[t]o distinguish between murder and 'mercy killing' would be to cross the line which prohibits intentional killing, a line which we think essential to preserve."). And this interest is not diminished by the fact that—in some class of cases involving the refusal of care—the waters of that river may appear muddy.

## CONCLUSION

For the reasons stated above, the judgments in *Glucksberg* and *Quill* should be reversed.

Respectfully submitted,

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to an election to commit suicide with . . . parties aiding and abetting therein").